STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E245	A. BUILDING 00 B. WING	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST AUGUSTINE HOME FOR THE AGED	2345 W 86TH ST INDIANAPOLIS, IN 46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 18, 19, 20 & 21, 2012 Facility number: 000389 Provider number: 15E245 AIM number: 100288920 Survey team: Diana Zgonc, RN, TC Connie Landman, RN Lora Brettnacher, RN Christi Davidson, RN Census bed type: NF: 40 Residential: 24 Total: 64 Census payor type: Medicaid: 34 Other: 30 Total: 64 Residential sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 27,	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	2012 by Bev Faulkner, RN			

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F0224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure a resident was free from misappropriation of property in that a resident's gold crucifix went missing and was not recovered for 1 of 3 residents who met the criteria for missing property. (Resident #2) Findings include: The record for Resident #2 was reviewed on 06/19/12 at 2:37 p.m. Diagnoses included, but were not limited to multiple sclerosis, osteoporosis and vitamin deficiency. The most recent annual Minimum Data Set [MDS] assessment, dated 5/9/12, indicated the resident was a 15 out of a possible 15 on the Brief Interview for Mental Status [BIMS] scale for cognition. A BIMS of 15 indicated the resident was cognitively intact.	F0224	To enable all to realize the importance of seeing that residents are free of any misappropriation of funds the following policy was adopted and each employee will be required to sign this policy. An inventory sheet will be filled out upon admission and any time the resident acquires something. new. The inventory sheet would state the value of any jewelry; if the the family chooses to leave it in the resident's possession. Sometimes it may be well to buy an in-expensive piece of jewelry that resembles the more expensive one. When a resident is not wearing an expensive piece of jewelry it should be locked in a secure box. Our policy does cover both property and funds. The in-service director will keep a running log of all who have signed this adedenum. Anyone failing to keep this policy will have disciplinary procedures up to and including dismissal. The Administrator will report the incident to the state and the police. The Administrator will keep a file on all concerns reported to her and what she did	06/25/2012

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	During an interview on 6/19/12 at 9:04 a.m., Resident #2 indicated she was missing a gold crucifix. Resident #2 could not remember the exact time frame it went missing. Resident #2 indicated the crucifix was not found and it was irreplaceable. A nurses note, dated 10/18/11 at 10:00 p.m., indicated, "Called CNA...very upset. Stated she had an 18 carat gold necklace on her bookshelf at 2 p [sign for and] missing by 4 p...." The note indicated charge nurse notified and POA [power of attorney] notified. A social service progress note, dated 10/25/11 at 1:40 p.m., indicated, "This writer has been away on vacation over last week - Told by [name of Unit Manager]...r/t [related to] loss of this Resident's necklace [sign for with] crucifix pendant '18 K [carat] gold!' and has had it over 20 yrs. [years]...no success finding necklace, which Res [resident] had left in her room on a shelf in small bookcase...left necklace for abt [about] 2 hr [hour] time and went back to room from activities - necklace gone...." A social service progress note, dated 10/25/11 and not timed, indicated,		to correct them. An in-service with the staff at change of shift will explain the importance of following this policy. The Sister on the unit will be responsible for conducting the investigation. The DON or another individual assigned by the administrator may help.	

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	"Writer called Res. friend...who confirmed the Resident's version of how loss occurred...states she is accepting it but very hard...'no hope of finding'...investigated [sign for and] report done - but [sign for no] success in finding anyway or if anyone, responsible for this loss...of course feels hurt [sign for and] locks door now if gone...." The social service note indicated the administrator was aware. A social service progress note, dated 11/25/11 at 1:00 p.m., indicated, "...Mood: calm - states she's not 'forgotten' necklace loss, but 'life goes on'...." A social service progress note, dated 11/29/11 and not timed, indicated, "...She...brought up for discussion the recent loss of a gold necklace, which continues to be investigated and followed by Administrator and others involved...." During an interview on 6/19/12 at 4:30 p.m., the investigation regarding the missing crucifix was requested from the Director of Nursing (DoN). During an interview on 6/20/12 at 9:59 a.m., the Unit Manager indicated a report was filed for the missing			

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	crucifix. On 6/20/12 at 9:45 a.m., a report filed by the Unit Manager regarding the missing crucifix, dated 10/18/11, was presented by the DoN. A type-written report, dated 10/18/11 and not timed and provided by the DoN, indicated Resident #2 reported an 18 carat gold crucifix and chain missing. The report indicated, "...reported she leaves it on the book case shelf whenever she removes it and this is only when out of the room for a scheduled bath...When she returned to her room...she immediately noticed that it was not in its usual place on the bookcase shelf...areas were searched and it was not to be found...related the situation to [name of Administrator]...." During an interview on 6/20/12 at 12:41 p.m., the Unit Manager indicated she was not aware if a police report had been filed or if the state survey agency had been notified. She indicated the administrator would make that decision. During an interview with the DoN on 6/20/12 at 12:45 p.m., she indicated			

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	when she returned from retreat and learned of the missing crucifix, the resident was asked the value of the crucifix, and a reimbursement was offered. The DoN indicated the resident and the POA declined the reimbursement indicating it was from another country and was not replaceable. During an interview on 6/20/12 at 2:05 p.m., the Administrator indicated the missing crucifix was not reported to the police or the state survey agency. The Administrator indicated there was suspicion a staff member, a CNA, took the gold crucifix, and the CNA was later terminated for other performance issues. The Administrator indicated the resident was "distraught" over the loss. A facility policy, titled, "Abuse Prohibition, Reporting and Investigation of Resident Abuse, Neglect and Mistreatment," dated 7/2011 and provided by the DoN on 6/19/12 at 9:00 a.m., indicated, "...Every Resident...is entitled to respectful, courteous treatment. The Facility will not tolerate rude, threatening or abusive behavior toward a Resident or any other mistreatment of a Resident. For purposes of this policy, 'mistreatment'			

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	includes the misappropriation of Resident's property...." 3.1-28(a)			

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to report an	F0225	All staff and residents will be informed that any time a staff member is short or cranky with a	07/09/2012

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	allegation of an employee being "cranky" to a resident and failed to report an allegation of misappropriation of a gold crucifix to the state survey agency for 2 of 3 reportable incidents reviewed. (#2, #41) Findings include: 1. The record for Resident #2 was reviewed on 06/19/12 at 2:37 p.m. Diagnoses included, but were not limited to multiple sclerosis, osteoporosis and vitamin deficiency. The most recent annual Minimum Data Set [MDS] assessment, dated 5/9/12, indicated the resident was a 15 out of a possible 15 on the Brief Interview for Mental Status [BIMS] scale for cognition which indicated the resident was cognitively intact. During an interview on 6/19/12 at 9:04 a.m., Resident #2 indicated she was missing a gold crucifix. Resident #2 could not remember the exact time frame it went missing. Resident #2 indicated the crucifix was not found and it was irreplaceable. A nurses note, dated 10/18/11 at 10:00 p.m., indicated, "Called		resident or other staff member this should be reported to the Sister on the unit who will immediately inform the Administrator. The Administrator with the assistance of the Sister on the unit and the DON will collect information from the involved parties and report to the state within 24 hours if an abuse did occur. Disciplinary measures will be taken up to and including termination. An employee will be suspended until the investigation is completed. When gathering information the resident's total medical history will be reviewed. At least prior to every care conference the resident will be interviewed as to how the staff is treating them. Each employee will sign the policy reminding them of respect. The residents will be given a notice stating that any time an aide is cranky with them or does not answer their bell to tell the Sister on their unit. The employee handbook states that an employee can be suspended with or without pay for up to three days.	

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	CNA...very upset. Stated she had an 18 carat gold necklace on her bookshelf at 2 p [sign for and] missing by 4 p...." The note indicated charge nurse notified and POA [power of attorney] notified. A social service progress note, dated 10/25/11 at 1:40 p.m., indicated, "This writer has been away on vacation over last week - Told by [name of Unit Manager]...r/t [related to] loss of this Resident's necklace [sign for with] crucifix pendant '18 K [carat] gold!' and has had it over 20 yrs. [years]...no success finding necklace, which Res [resident] had left in her room on a shelf in small bookcase...left necklace for abt [about] 2 hr [hour] time and went back to room from activities - necklace gone...." During an interview on 6/19/12 at 4:30 p.m., the investigation regarding the missing crucifix was requested from the Director of Nursing (DoN). During an interview on 6/20/12 at 9:59 a.m., the Unit Manager indicated a facility report was filed for the missing crucifix. On 6/20/12 at 9:45 a.m., a facility report filed by the Unit Manager			

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	regarding the missing crucifix, dated 10/18/11, was presented by the DoN. A type-written report, dated 10/18/11 and not timed and provided by the DoN, indicated, Resident #2 reported an 18 carat gold crucifix and chain missing. The report indicated, "...reported she leaves it on the book case shelf whenever she removes it and this is only when out of the room for a scheduled bath...When she returned to her room...she immediately noticed that it was not in its usual place on the bookcase shelf...areas were searched and it was not to be found...related the situation to [name of Administrator]...." During an interview on 6/20/12 at 12:41 p.m., the Unit Manager indicated she was not aware if a police report had been filed or if the state survey agency had been notified. She indicated the administrator would make that decision. During an interview with the DoN on 6/20/12 at 12:45 p.m., she indicated when she returned from retreat and learned of the missing crucifix, the resident was asked the value of the crucifix, and a reimbursement was			

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	offered. The DoN indicated the resident and the POA declined the reimbursement indicating it was from another country and was not replaceable. During an interview on 6/20/12 at 2:05 p.m., the Administrator indicated the missing crucifix was not reported to the police or the state survey agency. The Administrator indicated there was suspicion a staff member, a CNA, took the gold crucifix, and the CNA was later terminated for other performance issues. The Administrator indicated the resident was "distraught" over the loss. 2. The record for Resident #41 was reviewed on 6/19/12 at 3:39 p.m. Diagnoses included, but were not limited to hypertension, coronary atherosclerosis, osteoporosis, and chronic airway obstruction. The most recent annual Minimum Data Set (MDS) assessment, dated 5/6/12, indicated Resident #41 was a 15 out of a possible 15 on the BIMS scale for cognition which indicated Resident #41 was cognitively intact. During an interview on 6/18/12 at 10:46 a.m., Resident #41 answered			

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	"yes" when asked, "Has staff yelled or been rude to you?" Resident #41 indicated sometimes during dressing and bathing the CNA's were "cranky because they are understaffed." During an interview on 06/19/12 at 2:30 p.m., LPN #2 indicated Resident #41 had never indicated discontent with the CNA's that worked with her. LPN #2 indicated no other resident complaints had been voiced. LPN #2 indicated, "You see how friendly everyone is." LPN #2 indicated Resident #41 received a bath today and was on a Tuesday and Friday bath schedule. LPN #2 indicated Resident #41 required assistance with bathing and dressing. During an interview on 6/19/12 at 3:58 p.m., CNA #3 indicated that Resident #41 had indicated to her the day shift CNA's do not care for her the way she wants to be cared for. CNA #3 indicated Resident #41 indicated the CNA's are "mean." CNA #3 indicated she had informed LPN #4 of Resident #41's care concerns. During an interview on 6/19/12 at 4:04 P.m., LPN #4 indicated she was not aware of Resident #41's concerns. She indicated she would			

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	inform the DoN or the Unit Manager if she became aware of a resident care concern. She indicated she could not recall CNA #3 sharing information concerning Resident #41. LPN #4 indicated Resident #41 was always upbeat and without complaints. During an interview on 6/19/12 at 4:30 p.m., the DoN indicated she was not aware of any care concerns voiced from Resident #41. She indicated "that really puzzles me." During an interview on 6/20/12 at 8:32 a.m., the DoN indicated after investigating the concerns from Resident #41, these concerns were voiced to CNA #3 in December 2011, and the employee Resident #41 identified as being "cranky" was terminated in December for performance issues. On 6/20/12 at 9:45 a.m., the DoN provided a type-written letter, dated 6/20/12, describing the details of Resident #41's concerns. The letter indicated, "...[name of resident] stated that a staff member had been cranky to her and that she had told [CNA #3]...She stated that back in December, 2011 [name of resident] had told her that [name of employee] was cranky with her and did not			

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	answer her call light promptly...reviewed with [CNA #3] the importance of going to [reference to Unit Manager] immediately...The policy for reporting incidents was reviewed...." The report indicated Resident #41 identified the employee that was "cranky" to her. The letter indicated the employee had been terminated on December 21, 2011 and had not worked since December 6, 2011. The record lacked documentation of the allegation voiced in December being investigated at that time or reported to the state survey agency. 3.1-28(e)			

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to implement policies and procedures for allegations of abuse by not investigating and not reporting an allegation of a staff member being "cranky" to a resident and by not reporting an allegation of misappropriation of a gold crucifix for 2 of 3 incidents reviewed. (#2, #41) Findings include: 1. The record for Resident #2 was reviewed on 06/19/12 at 2:37 p.m. Diagnoses included, but were not limited to multiple sclerosis, osteoporosis and vitamin deficiency. The most recent annual Minimum Data Set [MDS] assessment, dated 5/9/12, indicated the resident was a 15 out of a possible 15 on the Brief Interview for Mental Status [BIMS] scale for cognition which indicated the resident was cognitively intact.	F0226	The Administrator will see that the State is properly informed and she will seek the help of the DON in seeing that this is done. The Administrator, the Sister on the unit and the DON will keep a running log of each incident that occurred.	07/16/2012

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	15E245	A. BUILDING 00 B. WING	06/21/2012

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	During an interview on 6/19/12 at 9:04 a.m., Resident #2 indicated she was missing a gold crucifix. Resident #2 could not remember the exact time frame it went missing. Resident #2 indicated the crucifix was not found and it was irreplaceable. A nurses note, dated 10/18/11 at 10:00 p.m., indicated, "Called CNA...very upset. Stated she had an 18 carat gold necklace on her bookshelf at 2 p [sign for and] missing by 4 p...." The note indicated charge nurse notified and POA [power of attorney] notified. A social service progress note, dated 10/25/11 at 1:40 p.m., indicated, "This writer has been away on vacation over last week - Told by [name of Unit Manager]...r/t [related to] loss of this Resident's necklace [sign for with] crucifix pendant '18 K [carat] gold!' and has had it over 20 yrs. [years]...no success finding necklace, which Res [resident] had left in her room on a shelf in small bookcase...left necklace for abt [about] 2 hr [hour] time and went back to room from activities - necklace gone...." During an interview on 6/19/12 at 4:30 p.m., the investigation regarding			

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	the missing crucifix was requested from the Director of Nursing (DoN). During an interview on 6/20/12 at 9:59 a.m., the Unit manager indicated a facility report was filed for the missing crucifix. On 6/20/12 at 9:45 a.m., a facility report filed by the Unit Manager regarding the missing crucifix, dated 10/18/11, was presented by the DoN. A type-written report, dated 10/18/11 and not timed and provided by the DoN, indicated Resident #2 reported an 18 carat gold crucifix and chain missing. The report indicated, "...reported she leaves it on the book case shelf whenever she removes it and this is only when out of the room for a scheduled bath...When she returned to her room...she immediately noticed that it was not in its usual place on the bookcase shelf...areas were searched and it was not to be found...related the situation to [name of Administrator]...." During an interview on 6/20/12 at 12:41 p.m., the Unit Manager indicated she was not aware if a police report had been filed or if the state survey agency had been			

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	notified. She indicated the administrator would make that decision. During an interview with the DoN on 6/20/12 at 12:45 p.m., she indicated when she returned from retreat and learned of the missing crucifix, the resident was asked the value of the crucifix, and a reimbursement was offered. The DoN indicated the resident and the POA declined the reimbursement indicating it was from another country and was not replaceable. During an interview on 6/20/12 at 2:05 p.m., the Administrator indicated the missing crucifix was not reported to the police or the state survey agency. The Administrator indicated there was suspicion a staff member, CNA, took the gold crucifix, and the CNA was later terminated for other performance issues. 2. The record for Resident #41 was reviewed on 6/19/12 at 3:39 p.m. Diagnoses included, but were not limited to hypertension, coronary atherosclerosis, osteoporosis, and chronic airway obstruction. The most recent annual Minimum			

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	Data Set (MDS) assessment, dated 5/6/12, indicated Resident #41 was a 15 out of a possible 15 on the BIMS scale for cognition which indicated Resident #41 was cognitively intact. During an interview on 6/18/12 at 10:46 a.m., Resident #41 answered "yes" when asked, "Has staff yelled or been rude to you?" Resident #41 indicated sometimes during dressing and bathing the CNA's were "cranky because they are understaffed." During an interview on 06/19/12 at 2:30 p.m., LPN #2 indicated Resident #41 had never indicated discontent with the CNA's that worked with her. LPN #2 indicated no other resident complaints had been voiced. LPN #2 indicated, "You see how friendly everyone is." LPN #2 indicated Resident #41 received a bath today and was on a Tuesday and Friday bath schedule. LPN #2 indicated Resident #41 required assistance with bathing and dressing. During an interview on 6/19/12 at 3:58 p.m., CNA #3 indicated that Resident #41 had indicated to her the day shift CNA's do not care for her the way she wants to be cared for. CNA #3 indicated Resident #41 indicated the CNA's are "mean."			

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	CNA #3 indicated she had informed LPN #4 of Resident #41's care concerns. During an interview on 6/19/12 at 4:04 P.m., LPN #4 indicated she was not aware of Resident #41's concerns. She indicated she would inform the DoN or the Unit Manager if she became aware of a resident care concern. She indicated she could not recall CNA #3 sharing information concerning Resident #41. LPN #4 indicated Resident #41 was always upbeat and without complaints. During an interview on 6/19/12 at 4:30 p.m., the DoN indicated she was not aware of any care concerns voiced from Resident #41. She indicated "that really puzzles me." During an interview on 6/20/12 at 8:32 a.m., the DoN indicated after investigating the concerns from Resident #41, these concerns were voiced to CNA #3 in December 2011, and the employee Resident #41 identified as being "cranky" was terminated in December for performance issues. On 6/20/12 at 9:45 a.m., the DoN provided a type-written letter, dated			

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	6/20/12, describing the details of Resident #41's concerns. The letter indicated, "...[name of resident] stated that a staff member had been cranky to her and that she had told [CNA #3]...She stated that back in December, 2011 [name of resident] had told her that [name of employee] was cranky with her and did not answer her call light promptly...reviewed with [CNA #3] the importance of going to [reference to Unit Manager] immediately...The policy for reporting incidents was reviewed...." The report indicated Resident #41 identified the employee that was "cranky" to her. The letter indicated the employee had been terminated on December 21, 2011 and had not worked since December 6, 2011. The record lacked documentation of the allegation voiced in December being investigated at that time or reported to the state survey agency. A facility policy, titled, "Abuse Prohibition, Reporting and Investigation of Resident Abuse, Neglect and Mistreatment, dated 7/2011 and provided by the DoN on 6/19/12 at 9:00 a.m., indicated, "...Every Resident...is entitled to respectful, courteous treatment. The			

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	Facility will not tolerate rude, threatening or abusive behavior toward a Resident or any other mistreatment of a Resident. For purposes of this policy, 'mistreatment' includes the misappropriation of Resident's property...1. All of the following are examples of possible abuse, neglect or mistreatment and must be reported immediately to the Unit Supervisor and charge nurse...c. Verbal abuse, including rude, disrespectful or threatening language...e. Missing Resident property...6. As soon as possible, but within no more that twenty-four (24) hours of the suspected abuse...the Administrator shall notify the Office of Health Care Quality and the local policy (sic) department...7. The Administrator...shall conduct an investigation and report all results below...." The DoN indicated the Office of Health Care Quality would be the state agency. 3.1-28(a)			